An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0532
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Mis-selling Delayed or inadequate communication Dissatisfaction with customer service Failure to provide correct information
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a whole of life insurance policy with the Provider in **February 2001**. The Complainants believe this policy was mis-sold to them. The Complainants also contend that the Provider failed to adequately assess and review the continued suitability of the policy and failed to properly advise them during a number of meetings.

Jurisdiction

The Complainants have made a complaint alleging their insurance policy was mis-sold to them. The Complainants assert that they cancelled the policy in March 2016 incurring a substantial loss on their investment. They have also made a complaint in respect of the Provider's conduct in the years that followed the inception of their policy. This Office issued a *Preliminary Opinion* dated **24 October 2018** declining to investigate this complaint due to the time at which the policy was sold and the alleged mis-selling occurred. Following a number of submissions by the parties, a *Final Determination* as to jurisdiction was issued on **1 November 2019**. This Office determined that the complaint regarding the alleged mis-selling of the policy fell outside the jurisdiction of this Office and as such, this aspect of the complaint would not proceed to formal investigation. Notwithstanding this, it was determined that the complaint, insofar as it related to the Provider's conduct following the inception of the policy, would be investigated. This aspect of the complaint concerns (i) the

Provider's failure to adequately review the policy and assess its continuing suitability; and (ii) the Provider's failure to properly advise the Complainants during two meetings.

The Complainants' Case

In a submission dated **8 October 2016** outlining their complaint, the Complainants explain that they wished to make a complaint regarding the mis-selling of a life insurance policy by the Provider. This submission focuses quite extensively on the alleged mis-selling of the policy. However, in light of the determination made by this Office regarding its jurisdiction to investigate certain aspects of this complaint, I do not propose to set out, to the same extent, those aspects of the Complainants' submission that relate to the alleged mis-selling.

In **February 2001**, the Complainants purchased a life insurance policy from one of the Provider's agents. The First Complainant states that:

> *"I believe he and [the Provider] took unfair advantage of me and my wife and they exploited our lack of knowledge and understanding of their complex product, a whole of life policy, to the financial advantage of themselves and the financial disadvantage of me and my wife."*

The Complainants paid *"… the substantial sum of money of* ***€34,083.06*** *as of 18th January 2016, which we were never going to get back, as elderly pensioners in our seventies on only benefits, the policy kept rising until we were priced out of ever being able to afford to keep up the repayments …"*

The Complainants state they had no choice but to cancel the policy and lose €26,883.06 of their investment; receiving only €7,200.00 when the policy was cancelled. The Complainants *"… wiped out our savings account … to try and keep making payments and now we are left with no policy and no savings …"*

The Complainants make the point that the Provider failed to give adequate consideration to their ability to pay for the policy each year given that fact that *"… we were rapidly reaching retirement … How did they think that two pensioners were going to afford the astronomical payments that needed to be paid in to keep this policy going??"* The Complainants also believe that it was not sufficient for the Provider to send them a policy to read and sign *"… with these people having no understanding of the financial or insurance products, that by reading these documents this makes them fully aware of the products and the requirements …"* In their submission, it is stated that the Provider needs to take responsibility for *"… the continual inadequate assessment of the financial products suitability for myself and my wife as it is [the Provider's] responsibility to make sure all their representatives use an ethical approach when selling products."*

Referring to the welcome letter received from the Provider, the Complainants observe that:

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> *"[w]hen my wife and I retired/reached retirement age, why as an insurance company with all the knowledge and understanding of their products, which was looking forward to a 'Valuable relationship' with us, did someone not look and see, these people are now retired, how will they keep up the repayments? Did they not stop to think; maybe we should reassess this."*

The Complainants also pose the question of *"… how do they expect two retired pensioners to keep up repayments on pensions?"* The Complainants continue by stating *"… for that last 15 years this policy has not provided any peace of mind to me or my wife; it is nothing but a millstone around my neck causing me undue worry and stress trying to keep up with the repayments."*

In resolution of this complaint, the Complainants wish to be compensated:

> *"… for the money [the Provider] have taken from us and the desperate situation we now find ourselves in … That the state still allows these types of companies to operate and prey on vulnerable elderly people with no understanding of financial products is a disgrace and this needs to be addressed. These policies are only suitable for 'The Rich' in society and normal working class people should never be targeted by these companies."*

In a submission dated **21 November 2018**, the Complainants' daughter, on behalf of the Complainants, submits that the Provider has a duty of care and fiduciary duty to make sure the Complainants had a risk appetite for the policy and had a full understanding of what was happening during the course of the policy. It is submitted that the annual letters sent by the Provider does not discharge this duty and that the Provider should have, for example, telephoned the Complainants each year. It is also submitted that the Provider did not act in the Complainants' best interests and pursued its own self-interest to the detriment of the Complainants.

In a submission dated **29 January 2019**, the point is made that it was only during a home visit in **2016** that the Provider's agent explained to the Complainants how the policy worked and:

> *"… this was the first and only time that [the Provider] explained to my parents what the policy was and what it involved. Before this they had no clue what they had taken out, this is clearly shown as on the basis of this conversation between my parents and [the Provider's] representative [Provider's agent], they then visited an independent financial adviser …"*

The Provider's Case

Policy Overview

The Provider explains that the Complainants' policy was a regular premium, unit linked whole of life policy and was set up on a dual life basis. It states that a major advantage of

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this policy was its flexibility to meet clients' protection requirements and adapt to their changing circumstances over time.

Premiums are invested in one or more funds of a clients' choice. Each fund is divided into a number of units of equal value which are valued once every working day. These unit prices can fall as well as rise. The Provider states that charges are deducted monthly from the unit account. On each anniversary of the policy, the premium and the protection benefits will increase by 5% without the need for any further medical underwriting queries. This optional increase, the Provider advises, protects against the effects of inflation and it can be stopped at any time at the request of a client.

If premiums are stopped and a policy still has value in the account, this fund can be used to keep the existing life cover going until the units are exhausted. The Provider states that clients can also encash the remaining fund value if they decide to cancel their life cover with immediate effect.

The Provider outlines that when the Complainants' plan started in **2001**, they were availing of £50,000 (€63,487) life cover each at a monthly premium of £105 (€133.32) and before their last policy review, the Complainants were covered for €125,700 life cover each, at a combined monthly premium of €263.97.

Five Year Reviews

The Provider explains, with the five yearly reviews for protection policies, there is usually no direct guidance given on these to clients in the annual information updates provided there is no action required by the clients. The Provider states that no direct correspondence was given for this policy at the time of its review in **2011** as it was determined that the current premium would be sufficient to provide the selected life cover amount for a further five years.

The Provider also advises that if no action is required by the clients to amend their policy either to increase premiums or to reduce cover, in order to sustain the policy for at least the next 5 years, then the Provider does not issue specific correspondence to this effect. The plan will continue to run as the client had originally requested, unless a request to amend the policy is made.

The Provider states that the Complainants would have been informed at the inception of the policy about the estimated sustainability date of the policy and when the next relevant review together with any potential policy amendments would be required. The Provider points out that the sustainability date is also reported regularly to clients in their Client Information Updates.

The projected sustainability date given to the Complainants at the time the policy was incepted and in the subsequent Client Information Update letters, have consistently

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projected this policy would be sustained until around **May/June 2019**. This would have indicated that the next five year review requiring action would be **February 2016**.

In a submission dated **20 April 2020**, the Provider has stated it *"… would like to clarify for the client's representative that our responses … relate to our Actuarial Department Reviewing the policy for its ongoing sustainability based on the premiums and level of cover provided…."*

Supplementing Cost of Cover

The Provider advises, in the context of its flexible life plans, *"… these charges are always taken out of the account value, with funds therefrom coming in the first place from the premiums paid."*

The Provider states there is a period in the initial phase of the policy where the account value remains at a nil value as accumulated charges in that phase outweigh the total premiums paid. After this phase, the policy value becomes positive and starts growing above €0 and at that point, the accumulation will support the future cost of the protection benefits which may be higher in the future years. The Provider advises that the date on which the policy value started growing from €0 for the Complainants' policy was **24 February 2005**.

The Provider explains that no correspondence is given to clients to indicate when their policy value has reached this point. However, an indication on the general protection of the account values by year is given to clients through detailed illustrations given at the commencement of a policy.

Visits from the Provider

The Provider states that one of its sales advisors visited the Complainants on **16 January 2016** to review their policy. The sales advisor explained the policy options available to the Complainants to keep the cover in place until the next five year anniversary review.

The Provider states that it has records of telephone contact with the Complainants regarding reviewing the policy in **2013**, **2014** and **2015**. The next record of a personal visit and review was on **1 March 2012**.

The Provider submits that *"[w]e have no records of a meeting having taken place after the client cancelled their policy. The clients last [sales advisor] also confirmed that he only called out to the clients on the one occasion … in order to review the policy …"*

Sustainability of the Policy

The Provider outlines that policies like the Complainants' are designed to be fully flexible in nature with a key advantage of not requiring any further medical evidence once the policy

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is set up and the relevant premiums continue to be paid. When the policy commenced in **2001**, the Complainants were availing of €63,487 of life cover at a monthly premium of €133.32. Before their policy review, the Complainants had life cover of €125,700 each at a premium of €263.97 per month because they availed of the annual 5% indexation option.

The Provider submits that at any stage, the Complainants could have contacted it to reduce their cover if they felt it was not sustainable or if their circumstances changed and they no longer required the same level of cover. The Provider states that it tailors its policies to suit its clients' needs and can work around individual needs and requests.

The Provider states that prior to this complaint, it was not aware of the Complainants' dissatisfaction with the premium or policy. The Provider advises that it always encourages its clients to contact either its head office or their local branch or representative if they have any queries or wish to make any amendments to their policies.

Additionally, the Provider submits that the sustainability of the policy was well documented from the outset whereby the Complainants' chosen benefits and premium from **2001** were going to be sustainable for 13 to 14 years. During the 15 years that the clients were on cover, the Provider states that it has no records of the Complainants being unhappy with the premium and the level of cover. Nor does the Provider have any records of the Complainants calling to query or amend the policy. The Provider states that if at any stage it had been made aware of the Complainants' dissatisfaction, it would have been able to advise them about the various options available to them due to the flexible nature of their policy.

The Complaints for Adjudication

The complaints being investigated are that the Provider:

1. Failed to adequately review the Complainants' policy at its five year anniversary reviews in **2006** and **2011** and/or consider the continued suitability of the policy; and

2. Failed to adequately and/or reasonably advise the Complainants during the course of two meetings; the first estimated to have been held between **2010** and **2016**, and the second in **2016**.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 30 July 2020, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of my Preliminary Decision, the parties made the following submissions:

1. E-mail and attachments from the Provider to this Office dated 20 August 2020.
2. Letter from the Complainants' representative to this Office dated 31 August 2020.
3. Letter from the Provider to this Office dated 14 September 2020.
4. E-mail from the Complainants' representative to this Office dated 14 September 2020.

Copies of these submissions were exchanged between the parties.

The Provider advised this Office under cover of its e-mail dated 17 September 2020 that it had nothing further to add.

Having considered these additional submissions and all of the submissions and evidence furnished by both parties to this Office, I set out below my final determination.

Policy Documents

It is not disputed that the Complainants were provided with a number of documents when the policy was incepted in **February 2001**. I note these documents include a *Life Plan Illustration*, *Life Plan Provisions* and *Protection Plan Important Information*.

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Client Information Update

The Provider furnished the Complainants with *Client Information Updates* in respect of their policy on an annual basis. However, the parties have not furnished all of these updates. The earliest of those updates that have been provided to this Office is dated **18 January 2011**.

This update states:

> *"…*
>
> *We would like to advise you that your premium and benefits are due to increase automatically in accordance with your Life Plan Provision. The revised details of your policy are:*
>
> ***Revised Premium:*** *€217.17 payable monthly …*
>
> | ***Revised Benefits:*** | ***Life 1*** | ***Life 2*** |
> |---|---|---|
> | *Life Cover* | *€103,413* | *€103,413* |
>
> *These alterations will take effect from 23rd February 2011 and are reflected in the revised policy values on the next page. This is an important notice please retain it with your policy documents.*
>
> *If you need any further assistance, please do not hesitate to contact … at the above telephone number."*

A *Revised Policy Values* document was also enclosed with the update. This outlines the growth in the value of the policy and also conveys the following information:

> *"…*
>
> *Policy Sustainability Date: 13-May-2019*
>
> ***Notes:***
>
> 1. *…*
> 2. *…*
> 3. *… In practice, unit prices may fall as well as rise and the actual returns will depend on the growth achieved.*
> 4. *Premiums and Benefits have been assumed to increase automatically at a rate of 5% a year.*
> 5. *Based on the assumptions used for this illustration and where a Policy Sustainable Date applies, premiums are sufficient to continue cover until this date.*
>
> *…"*

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Similar updates were sent to the Complainants in **January 2012** and **January 2013**.
In light of the introduction of the Consumer Protection Code 2012 (the **Code**), the format of the Provider's updates changed in line with the requirements of the Code. The Complainants were provided with a *Client Information Update* on **20 June 2013**.

This letter, while similar to previous updates, enclosed a *Table of premiums, benefits and charges* outlining the performance and projected performance of the policy. Annual updates were furnished to the Complainants in **January 2014** to **January 2016**.

On the **2016** *Client Information Update*, the Complainants are advised:

> *"… **However please note that, in accordance with your Policy Provision, we have recently reviewed the premium being paid into your policy and have established that it is not sufficient to meet the cost of the protection benefits being provided until your next policy review in five years.** …"*

I note that from the *Client Information Updates*, the monthly premium rose from €217.17 in **2011** to €263.97 in **2015**.

Anniversary Policy Review

Under the terms of the policy, policy reviews were scheduled to take place every five years. The parties have not furnished any correspondence in respect of the first or second five yearly reviews which were due to take place in **2006** and **2011**. However, on the third anniversary policy review, the Provider wrote to the Complainants on **19 January 2016**, advising:

> *"In accordance with your Life Plan Provisions your premiums and benefits increase each year to provide protection against the effects of inflation. Every five years we review your plan to check that the premium is sufficient to maintain the benefits until the next review.*
>
> *Plans with a high level of cover relative to the premium, such as you chose, were written on the basis that cover could only be maintained for a limited period. Our review shows that this period ends before the next five yearly review. You therefore have the following options:*
>
> *The benefits, after the annual indexation due on 23rd February 2016 are:*
>
> | | | |
> |---|---|---|
> | *Revised Benefits:* | *Life 1* | *Life 2* |
> | *Life Cover* | *€131,985* | *€131,985* |
>
> ***Option 1***
>
> *To maintain these benefits until the next five yearly review will require you to increase the premium to €420.20 each month.*

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…

Option 2

To maintain these benefits until the next ten yearly review will require you to increase the premium to €665.22 each month.

Option 3

The premium after the annual indexation is €277.17. This will maintain the following benefits until the next five yearly policy review:

Revised Benefits	*Life 1*	*Life 2*
Life Cover	*€106,346*	*€106,346*

Option 4

You may increase your benefits and premium by the amount of the normal annual indexation. This gives:

Revised Benefits	*Life 1*	*Life 2*
Life Cover	*€131,985*	*€131,985*

Your plan will continue until there are no more units to pay for the benefits. Based on investment returns of 6.5% each year we estimate your cover will continue for another 3 years and 9 months. This is not a guarantee and the actual length will depend on how investments perform. As this point all benefits will cease and your plan will stop.
…

If you have any further queries in relation to your policy, please do not hesitate to contact me on … or alternatively your Sales Associate …"

Further Correspondence

On **25 January 2016**, the Provider wrote to the Complainants as follows:

"I refer to recent instructions to amend the above policy and enclose the following documentation:

1. Revised Policy Illustrations

2. Endorsement Policy Schedule

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…

> *If after reading this letter and examining the policy documents you feel the Policy Alteration is not suitable for your particular needs, you may cancel this alteration by returning the alteration documents with a written instruction … On cancellation, the Policy Alteration will cease immediately and the policy will continue as before the alteration. …"*

Following an enquiry from the Complainants, the Provider forwarded them a policy illustration on **10 March 2016**. The Complainants' policy was enchased on **16 March 2016**.

Meetings with the Complainants

There is a conflict between the parties as to when certain of the meetings the subject of this complaint took place. While it is suggested by the Complainants that two meetings took place prior to **2016**, it is acknowledged that they cannot recall the precise dates of these meetings. The Complainants contend that a meeting took place in or around **26 May 2011**. The Provider's documentation suggests that a meeting was held on **1 March 2012** but this is disputed by the Complainants. However, it does not appear to be disputed that a meeting took place in or around **16 January 2016**.

Describing a meeting that took place between the Provider's agent and the Complainants, it is stated in their daughter's submission dated **21 November 2018**:

> *"In the last few years of the policy they had a man visit them from [the Provider], my parents cannot remember the dates but [the Provider] should have this on file, during the visit one man advised that they had approx. €5,500 in their pot (this is the term used by [the Provider]). The man advised them that they could take this out now if they wanted and use it to get something they needed, they thought about this after the man left and decided to do this. They then called and spoke to a woman in [the Provider] and she advised then that this was not correct … so they were misinformed again by [the Provider]."*

The next meeting to take place is recounted as follows:

> *"During another visit from a representative of [the Provider] the following options were laid out to my parents when they explained the financial detriment the policy was putting them in:*
>
> - *Could one of your children take over the policy?*
> - *Could they make the payments on your behalf?*
> - *They could let [the Provider] keep taking the current direct debit out every month and then to make up the shortfall if they would agree that [the Provider] could*

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use the current €7,500 which was in their pot to make up the shortfall until it ran out. …

- *Close the policy and take the remaining €7,500 of their remaining €34,083.06 investment."*

In a submission dated **3 December 2018**, it is stated:

> *"In relation to when they had visits for a representative for [the Provider] my parents could not remember exact dates, but they know that an older gentleman visited them twice at their home before 2016 and a younger man visited them in 2016 …"*

Record of Client Contact

The Provider has prepared a list of contacts with the Complainants from **2006** to **2015** generated from its IT system. This list outlines the various meetings and telephone contacts between the Provider and its agents, and the Complainants. The Complainants strongly dispute the accuracy of this list.

In a submission dated **8 April 2020**, a number of observations are made in respect of the list prepared by the Provider on the Complainants' behalf. I note the following observations:

> *"…*
>
> *26/05/2011 - Anniversary – contacted by phone, policy review – (Advisor at time = …)* ***In relation to this contact my parents have advised that this was not a phone call, it was a personal visit to their home. As I have documented in previous letters, it was during this home visit the man advised that they had approx. €5,500 in their pot (this is the term used by [the Provider]). The man advised them that they could take this out now if they wanted and use it to get something they needed, they thought about this and decided to do this. They then called and spoke with a woman in [the Provider] and she advised them that this was not correct*** *…*
> *26/07/2011 – Client called Head Office to query Current Policy Value - Spoke to ….*
>
> ***My parents state that they only called [the Provider] once, and this was on this basis of what they had been told by [the Provider's agent] during the home visit about taking out a pot of money.*** *…*
>
> *01/03/2012 – Anniversary – Contacted in person, policy review …* ***My parents again adamantly state this man did not visit them at their home a second time, if he had of they would have raised with him why he gave them incorrect information about taking out a pot of money at the home visit in 2011.***
>
> *13/02/2013 …* ***My parents again adamantly state this man did not call them on their phone at home, if he had of they would have raised with him why he gave them incorrect information about taking out a pot of money at the last home visit.***

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24/02/2014 … ***My parents again adamantly state this man did not call them on their phone at home, if he had of they would have raised with him why he gave them incorrect information about taking out a pot of money at the last home visit.***

24/02/2015 … ***My parents again adamantly state this man did not call them on their phone at home, if he had of they would have raised with him why he gave them incorrect information about taking out a pot of money at the last home visit."***

Reasons for not Complaining

An explanation as to why the Complainants did not complain about the Provider's conduct at an earlier date is offered in a submission dated **3 December 2018**:

"…

- *They didn't know that they could complain, they thought that because they had been caught out by [the Provider] in taking out this policy that it was their fault and there was nothing they could do.*
- *They didn't know what the policy was and they didn't know that it would rise so substantially year on year, they were not told this when the policy was taken out.*
- *They were embarrassed that they had been fooled into taking this policy out and were too embarrassed to tell anyone in the family and ask for help with what to do, they only advised myself after they had cancelled the policy …*
- *Before they cancelled the policy they went and spoke to an Independent Financial Advisor … when they showed the gentleman what they had been sold and were trying to keep up paying, he actually asked 'I hope you don't mind me asking this question, but are you rich?' He then went on to explain that the reason he asked this question was because these types of policies are only suitable for wealthy people. …"*

<u>The First Complaint</u>

The first complaint relates to the asserted failure on the part of the Provider to adequately review the Complainants' policy at its five year anniversaries in **2006** and **2011**. This aspect of the complaint also relates to the Provider's asserted failure to consider the continued suitability of the policy.

In its response to this complaint, the Provider did not furnish any documentation in respect of either the **2006** or the **2011** anniversary reviews, whether in the form of correspondence sent to the Complainants or internally generated documentation; nor has the Provider explained in any particular detail, how each of these reviews were conducted or what was

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done in preparation for them. While meetings appear to have taken place in **October 2006** (described as an *Anniversary Visit*) and **May 2011**, neither the Complainants nor the Provider have been in a position to recount in any great detail what was discussed at these meetings. There is also a distinct lack of documentation from the Provider in respect of these meetings.

I am satisfied that both meetings took place after the introduction of the ***Consumer Protection Code 2006*** (the **2006 Code**). I note that clause 49 of the 2006 Code states:

> *"49 A regulated entity must maintain up-to-date consumer records containing at least the following:*
> *…*
>
> *e) all correspondence with the consumer and details of any other information provided to the consumer in relation to the product or service;*
> *…*
>
> *h) all other relevant information concerning the consumer"*

In my Preliminary Decision I stated that "*from the evidence furnished to this Office by the Provider in response to this complaint, it is patently clear that it has failed to maintain adequate records in respect of the Complainants and their policy.*

*Therefore, taking these matters into consideration, I am not satisfied that the Provider has demonstrated that it performed adequate reviews in respect of the **2006** and **2011** anniversary policy reviews"*

The Provider has, in its post Preliminary Decision submission, challenged this statement. It details that:

> "*We believe this is fundamentally incorrect and represents a misunderstanding of the policy review process for our Unit-Linked Flexible Life policies. The five-yearly policy review process, which is an automated process performed by our Policy Administration IT System, works as follows:*
>
> - *Policy review at year 5: Generally, all our policies are issued on the expectation that they will be sustainable for at least 10 years. So, while we always conduct a policy review at year 5, the requirement to increase the premium at that point is rarely, if ever, applied by us. For this policy we have a record on our IT System of the first policy review that was performed in 2006.*
>
> - *Subsequent policy reviews: The first step is to produce the figures required for the policyholder's annual Client Information Update, including projected future encashment values and projected sustainability date. The IT System then performs a check to identify if the policy is sustainable to its next fifth anniversary. If so, as was the case for this policy in 2011, the policy review process discontinues and no further action is required. If the policy is not sustainable to its next fifth anniversary, the appropriate policy options are generated and a letter is sent to*

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the policyholder accordingly. Our IT System has a record of the projected figures that were checked for this policy as part of the policy review in 2011.

Section 2.5 of the Policy Provisions (see Appendix 3, Section 3.1) state that we will write to the policyholder only in the instance where the policy review process has calculated that a premium increase is required. Therefore, we have acted in full accordance with the Policy Provisions, which do not include an obligation to communicate where no premium increase is required"

While I welcome the Provider's clarification, albeit at this late stage, regarding how each of these reviews were conducted, I am not convinced that it has demonstrated that it performed adequate reviews in respect of the 2006 and 2011 anniversary policy reviews and it most certainly did not communicate the process appropriately or sufficiently to the Complainants.

I note that Section 2.5 of the policy provisions state:

"*Once every five years we will review your Policy. This is to check whether the Premium is likely to be able to maintain the Protection Benefits for a further five years. If this review shows the Premium is insufficient to maintain the Protection Benefits we will increase the Premium to a level that we estimate will be sufficient to maintain the Policy in force for the next five years. This increase will be in addition to the increase in Provision 2.3 (a). We will advise you in writing if any premium increase is required. You will also be advised of other options available to you should you not wish to increase your Premium.*

If you make a change to your Policy we will also review your Policy. The Actuary may, under the terms of Provision 2.1, require that we review your Policy at times other than every five years"

While the Provider submits that "*Section 2.5 of the Policy Provisions* […] *state*[s]s *that* [the Provider] *will write to the policyholder only in the instance where the policy review process has calculated that a premium increase is required".* This is not in fact what Section 2.5 states.

While the section details that the Provider "*will advise you in writing if any premium increase is required. You will also be advised of other options available to you should you not wish to increase your Premium"* it does not specify that it will "*only*" write in such instances. I find that it is reasonable to expect from a Provider that such important events such as the policy review/assessment would be documented, and the outcome of both reviews should have been communicated clearly and unambiguously to the Complainants.

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In relation to the visit which appears to have occurred in **May 2011**, in my Preliminary Decision I detailed that "*neither the Complainants nor the Provider have been in a position to recount in any great detail what was discussed at these meetings".*

In response to the above, the Provider has, in its post Preliminary Decision submission, submitted to this office additional documentation which it believes demonstrates what was discussed at this meeting.

In its post Preliminary Decision submission, the Provider details:

> "*Having reviewed your findings,* [the Provider] *have now enclosed additional documents relating to the Servicing of the policy and the Protection Policy Review Meetings that took place with* [the Complainants] *in 2011 and 2012. The Personal Visit sheets should assist you in determining that* [the Complainants] *were adequately advised and that the fullest disclosure of information pertaining to this Protection Plan was clear and comprehensible".*

The Provider explains its rationale for why the documents were not submitted as part of the Provider's formal response to this office and were submitted now as part of the post Preliminary Decision exchange. It details that:

> *"due to access restrictions to our Head Office and our off-site storage facility, coupled with staff working remotely, and our belief that these documents at the time were not essential to the investigation process*, [the Provider] *did not include the actual review sheets with our response to your schedule of questions. We apologise for this oversight on our part but trust you will understand the prevailing circumstances at the time. Having considered your preliminary decision and with the easing of restrictions,* [the Provider] *have now located and included the following documents:*
>
> - *Protection Policy Review Sheet – Personal Visit record sheet for a meeting that took place on 20th July 2011 with* [the Complainants]. *(Attached as Appendix 1).*
>
> - *Protection Policy Review Sheet – Personal Visit record sheet for a meeting that took place on 22nd February 2012 with* [the second named Complainant]. *(Attached as Appendix 2)".*

The submitted documentation are brief, both are single scanned pages baring the signature of both Complainants in 2011 and only the second named Complainant in 2012.

The Complainants' signatures come after the following statement:

- *I/We have been updated on the current benefits and premium on my/our policy.*

- *I/We understand that the policy is unit linked Whole of Life and the policy sustainability date has been explained.*

/Cont'd…

- *I/We have been made aware of the current fund allocation on the policy.*

- *I/We understand that the premiums and benefits under my/our policy have and will continue to increase by 5% each year."*

I note that the Provider has no notes or documentation to accompany this document and while in addition to the above, the Provider states that it contacted the representative of the Provider who attended these meetings and that he:

> *"confirmed that he recalls meeting* [the Complainants] *in person in 2011 and* [the second named Complainant] *in person in 2012. He confirmed that these meetings took place at the* [Complainants'] *home*. [the Provider's representative] *confirmed also that he addressed all points listed in the aforementioned Protection Policy Review Sheets"*

While I welcome that the Provider submits it has contacted the former employee regarding this matter, it remains that the Provider has not provided a written statement or evidence of the discussion which took place at the time, and I do not believe that 'Protection Policy Review Sheets' alone are sufficient evidence to demonstrate that the Provider conducted adequate reviews in respect of the **2006** and **2011** anniversary policy reviews and communicated this to the Complainants.

In terms of the continued suitability of the policy, I am not satisfied that any of the Consumer Protection Codes in effect between **2006** and **2016** impose a continuing obligation on a financial services provider to continually assess the suitability of a product or service. This duty generally only arises prior to or at the time a product or service is being offered or when a subsequent product or service is being offered. Furthermore, while a financial services provider is obliged to act in the best interests of a consumer, I am not satisfied this necessarily gave rise to an obligation to continually assess the suitability of the Complainants' policy.

While the Complainants were dissatisfied with the policy, there is no evidence to suggest that this was ever brought to the attention of the Provider. Based on the evidence in this complaint, I am not satisfied that the Provider was aware of or ought reasonably to have been aware of the Complainants' circumstances or dissatisfaction with the policy which would have required the Provider to reassess the continuing suitability of the policy.

The Second Complaint

The second complaint relates to the conduct of the Provider during the meetings that took place with the Complainants between **2011** and **2016**. The evidence in this complaint suggests that three meetings were held during this period on **25 May 2011**, **1 March 2012** and **16 January 2016**. There is a dispute as to whether the second meeting did in fact take place. However, I am satisfied it is likely that a meeting may have taken place in **March 2012**.

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It is quite clear from the parties' evidence and the documentation furnished that there is a distinct lack of information relating to all three meetings. For example, beyond the *Record of Client Contact*, the Provider has not furnished any details of the above meetings; no notes or records have been furnished nor have statements been prepared by those who were in attendance.

I note, however, that one particular agent is no longer employed by the Provider. However, no explanation has been given of any attempts to obtain a statement from this individual. There is also an absence of correspondence sent to the Complainants and internal records in respect of the first two meetings. Equally, the Complainants have been unable to recall any precise details of what occurred during the **May 2011** and **January 2016** meetings.

In my Preliminary Decision I had stated that "*In light of the evidence in this complaint, I am unable to determine whether or not the Complainants were adequately advised during the **May 2011** and **March 2012** meetings. In any event, it is not clear what advice was supposed to have been given during these meetings or what advice was sought".*

As I have already pointed out, the Provider has, in its post Preliminary Decision submission furnished additional documentation regarding these meetings.

As detailed above the Provider submits, as part of its post Preliminary Decision submission, that:

> "*Having reviewed your findings,* [the Provider] *have now enclosed additional documents relating to the Servicing of the policy and the Protection Policy Review Meetings that took place with* [the Complainants] *in 2011 and 2012. The Personal Visit sheets should assist you in determining that* [the Complainants] *were adequately advised and that the fullest disclosure of information pertaining to this Protection Plan was clear and comprehensible".*

I note the Complainants' representatives post Preliminary Decision submission in which she "*wholly dispute*[s] *that* [the Provider's representative] *adequately advised* [the Complainants] *and he was not clear and comprehensible*".

The Complainants' representative further questions "*what was the purpose of the visit in 2012? Was this a pre-arranged house call, as there is absolutely no circumstances under which* [the first named Complainant] *would have left* [the second named Complainant] *alone to deal with an insurance man visiting, this can only mean this was not pre-arranged and that it was a cold call".*

In this instance the lack of documentary evidence has resulted in a lack of clarity as to why the **2012** meeting only involved one of the policyholders. As the Provider has not furnished any details of the above meetings; no notes or records have been furnished nor have statements been prepared by those who were in attendance, I remain unable to determine

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whether or not the Complainants were adequately advised during the **May 2011** and **March 2012** meetings.

The Complainants' representative has questioned in her post Preliminary Decision submission, why the date of signature on the '*Protection Policy Review Sheets'* does not align with the "Records of Contact Client-Personal and/or contact by phone call" timeline submitted by the Provider to this office as part of its formal response.

The Complainants' representative queries why the "*signed policy review from 2011 is signed and dated 20th July 2011 but in relation to the* "*Records of contact – Personal and/or contact by phone call" provided by* [the Provider] […] *it is noted that the anniversary policy review was on 26th May 2011 and this was a phone call, 2 months before the actual visit took place?"*

The Complainants' representative further questions why "*the policy review which was signed and dated by* [the second named Complainant] *and* [the Provider's representative] *is from 22nd February 2012, but it is noted with the "Record of contact as having occurred on 1st March 2012".*

The Provider responded to the above points in its second post Preliminary Decision submission in which it states in relation to the first question "*It would have taken a period of time for the Policy Servicing Sheets to be handed in and then updated on our system*". It then details that in relation to point two that "[the Provider's] *Advisors will call clients first to ascertain if they require the Advisor to visit them to review their policy or to answer any queries that they may have. The agreed appointment can often be weeks or months later if that is what is agreed between the client and the advisor*".

While I note the Provider's response, I am not entirely satisfied that its response demonstrates that it correctly logged/captured its contact with the Complainants. While I note that it suggests it "*would have taken a period of time for the Policy Servicing Sheets to be handed in and then updated on our system",* it would be prudent to have notes and/or amendments which would correctly capture the type of contact and the date it correctly occurred.

In terms of the **January 2016** meeting, no note or memo has been furnished by the Provider in respect of this meeting nor has a statement been submitted by the agent who attended this meeting. However, having considered the documentation furnished to the Complainants in **January 2016** and the comments made in a submission dated **29 January 2016** to the effect that *"… this was the first and only time that [the Provider] explained to my parents what the policy was and what it involved"*, I am not satisfied that the Provider failed to adequately and/or reasonably advise the Complainants during the **January 2016** meeting.

I accept that the Provider has not maintained appropriate records in respect of its interactions with the Complainants as clearly mandated by the various iterations of the Consumer Protection Code. Furthermore, it has furnished no explanation as to why this is

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the case. I am satisfied that if better records were maintained by the Provider, I would have been better able to assess this complaint.

Provision 49 of the Consumer Protection Code 2006 (which was fully effective from **01 July 2007**) outlines as follows;

> *"A regulated entity must maintain up-to-date consumer records containing at least the following*
>
> *a) a copy of all documents required for consumer identification and profile;*
> *b) the consumer's contact details;*
> *c) all information and documents prepared in compliance with this Code;*
> *d) details of products and services provided to the consumer;*
> *e) all correspondence with the consumer and details of any other information provided to the consumer in relation to the product or service;*
> *f) all documents or applications completed or signed by the consumer;*
> *g) copies of all original documents submitted by the consumer in support of an application for the provision of a service or product; and*
> *h) all other relevant information [and documentation] concerning the consumer.*
>
> *Details of individual transactions must be retained for 6 years after the date of the transaction. All other records required under a) to h), above, must be retained for 6 years from the date the relationship ends. Consumer records are not required to be kept in a single location but must be complete and readily accessible."*

It is clear the Provider is obliged to retain that documentation on file for six years from the date the relationship with the Complainant ended. It is unclear to me why certain documentation has not been retained by the Provider. The Provider is not in compliance with the Code in this regard. This is most disappointing.

In my Preliminary Decision I stated "*I would emphasise the importance of carrying out policy reviews and communicating in the clearest possible terms the outcome of those reviews and in particular informing the Complainants of the ability of the fund, as it decreases, to pay for the policy cover and the implications of this decrease, at an early stage. With this knowledge, the Complainants would have had the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of a higher surrender value.*

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The ability to make alternative arrangements for cover in their younger years may also have been available to the Complainants".

The Provider has, in its post Preliminary Decision submission, taken issue with the use of the term '*investment'* in respect of the Complainants' policy.

The Provider submits in its post Preliminary Decision submission that:

> *"The following points are made in the Preliminary Decision of the FSPO:*
>
> - *Page 1; "The Complainants cancelled the policy in March 2016 incurring a substantial loss on their investment.*
>
> - *Page 15; "Furthermore, I would emphasise the importance of carrying out policy reviews and communicating in the clearest possible terms the outcome of those reviews and in particular informing the Complainants of the ability of the fund, as it decreases, to pay for the policy cover and the implications of this decrease, at an early stage. With this knowledge, the Complainants would have had the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of a higher surrender value."*
>
> *It is important to emphasise that this policy was a Protection Plan, whose primary purpose was to provide cover in the case of death. Although a policy value was attained after the early years, the policy was not designed to build up a savings fund or to provide an investment return. This was made clear in numerous written communications provided to the Complainants for example:*
>
> - *Important Information Document, provided at point of sale (see extract in Appendix 3, Section 3.2)*
> - *Policy Issue Pack (see extract in Appendix 3, Section 3.3)*
> - *Policy Servicing Form (dated 26th March 2001 – See Appendix 4)".*

The Provider further states that:

> "*Therefore, we believe it is unfair to state that the Complainants incurred a substantial loss on their investment, particularly given the level of protection cover that was provided for the period during which the policy was in force. In addition, the main purpose of the policy value attained, along with the ongoing premiums being paid, was to extend the protection cover provided through policy sustainability rather than to provide a surrender value (even though that option was available, for example where cover was no longer needed)".*

The Complainants' representative details in response to the Provider's post Preliminary Decision submission that she "*would like to state again, until January 2016* [the Complainants] *had paid into this policy €34,083.06 and were never at any point in the 15*

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years that the policy was running ever asked if this was still sustainable for them. If the correct reviews and advice had been provided and [the Complainants] *had the choice to withdraw from the policy or they had of been advised of the other options available to them that were most likely more suitable to their needs they would not have lost all this money trying to keep up payments on a policy that they did not need or want".*

I accept the Provider's submission that it is not correct to state that "*Complainants incurred a substantial loss on their investment"* as it is not specifically an investment product. I accept that the "*main purpose of the policy value attained, along with the ongoing premiums being paid, was to extend the protection cover provided through policy sustainability".* I also accept that the Complainants had ongoing insurance cover for the duration of the policy.

It is not possible to recoup the premiums for such cover because a claim was not made.

That said, the Complainants were entitled to be given sufficient information in relation to their policy to make decisions as to the continued suitability of the product.

I consider that the need for the fullest disclosure of information on a policy, and the associated keeping of records, is particularly required where the cover being provided is life assurance cover.

With regard to the provision of information to a consumer, the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.

I believe that there was a lack of information furnished to the Complainants, in particular, I believe key information relating to the reviews was not brought to the attention of the Complainants in the manner in which it should have been.

For the reasons set out in this Decision I partially uphold this complaint and direct the Provider to pay a sum of €7,000 in compensation to the Complainants.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (b) and (f)*** as the conduct of the Provider was unreasonable and an explanation for the conduct complained of was not given when it should have been given.

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Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €7,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

17 December 2021

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.